TITLE 10: CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.8 MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM

ARTICLE 2. ELIGIBILITY, APPLICATION, AND ENROLLMENT

Section 2699.6619 is amended to read:

2699.6619. Transfer of Enrollment.

(a) A subscriber shall be transferred from one participating health, dental, or vision plan to another if any of the following occurs:

(1) The applicant so requests in writing because the subscriber no longer resides in an area served by the participating plan in which the subscriber is enrolled, and there is at least one participating plan serving the area in which the subscriber now resides.

(A) If the program learns that the subscriber no longer resides in an area served by the participating health plan in which the subscriber is enrolled, but the applicant does not choose a new health plan within thirty (30) days of a written notice from the program, the program will enroll the subscriber in the Community Provider Plan in the subscriber's county of residence.

(B) If the program learns that the subscriber no longer resides in an area served by the participating dental plan in which the subscriber is enrolled, but the applicant does not choose a new dental plan within thirty (30) days of a written notice from the program, the program will enroll the subscriber in a participating dental plan in the subscriber's county of residence. If there is more than one (1) participating dental plan in the subscriber's county of residence, the program will alternate assignments between the participating dental plans so that the transfers are evenly distributed among the participating dental plans.

(C) If the program learns that the subscriber no longer resides in an area served by the participating vision plan in which the subscriber is enrolled, but the applicant does not choose a new vision plan within thirty (30) days of a written notice from the program, the program will enroll the subscriber in a participating vision plan in the subscriber's county of residence. If there is more than one (1) participating vision plan in the subscriber's county of residence, the program will alternate assignments between the participating vision plans so that the transfers are evenly distributed among the participating vision plans.

(2) The applicant or the participating plan so requests in writing because of failure to establish a satisfactory subscriber-plan relationship and the Executive Director of the Board or designee determines that the transfer is in the best interests of the subscriber and the program, and there is at least one other participating plan serving the area in which the subscriber resides.

(3) The program contract with the participating plan in which the subscriber is enrolled is canceled or not renewed.

(A) If the applicant does not choose a new health plan in response to two (2) written notices and three (3) phone calls from the program by the necessary date of transfer, the program will enroll the subscriber in the Community Provider Plan in the subscriber's county of residence.

(B) If the applicant does not choose a new dental plan in response to two (2) written notices and three (3) phone calls from the program by the necessary date of transfer, the program will enroll the subscriber in a participating dental plan in the subscriber's county of residence. If there is more than one (1) participating dental plan in the subscriber's county of residence, the program will alternate assignments between the participating dental plans so that the transfers are evenly distributed among the participating dental plans.

(C) If the applicant does not choose a new vision plan in response to two (2) written notices and three (3) phone calls from the program by the necessary date of transfer, the program will enroll the subscriber in a participating vision plan in the subscriber's county of residence. If there is more

than one (1) participating vision plan in the subscriber's county of residence, the program will alternate assignments between the participating vision plans so that the transfers are evenly distributed among the participating vision plans.

(4) An open enrollment request is submitted pursuant to Section 2699.6621.

(5) An AIM infant subscriber has a sibling(s) that is enrolled in a different health plan and is transferred pursuant to subsection (f).

(b) A subscriber shall be transferred from one participating health, dental, or vision plan to another if the applicant so requests in writing once within the first three (3) months from the original effective date of coverage in the program, or the applicant so requests in writing once within the first thirty (30) days from the effective date of coverage in a new plan following open enrollment, for any reason.

~~(c) A subscriber shall be transferred from one participating dental or vision plan to another if the applicant so requests in writing once within the first thirty (30) days from the original effective date of coverage in the program, or the applicant so requests in writing once within the first thirty (30) days from the effective date of coverage in a new plan following open enrollment, for any reason.~~

~~(d)~~ (c) If a subscriber is transferred pursuant to (a), (b), or (c) above, all other subscribers of the same applicant who live in the same household will also be transferred, unless the subscriber was transferred because the subscriber moved from the household.

~~(e)~~ (d) Transfer of enrollment shall take effect on the first day of a month and shall be within forty (40) days of approval of the request, or, if the transfer is pursuant to subsection (a)(3) above, shall take effect prior to the end of the contract. However, subscribers in inpatient facilities on the scheduled date of transfer shall not be transferred to a new health plan until the first day of the month following completion of their inpatient stay.

~~(f)~~ (e) The following provisions apply to the transfer of AIM infants from one participating health, dental, or vision plan to another:

(1) An AIM infant subscriber will be automatically transferred to the same health, dental, and vision plan that his or her sibling(s) is

enrolled in, effective on the first day of the infant's third calendar month of birth, unless one of the following occurs:

(A) The applicant submits a letter stating that the infant has a physical, developmental, behavioral, or emotional condition that requires continuity of care, and requests that the infant's sibling(s) be transferred to the infant's health plan, or

(B) The applicant submits a letter stating that the infant has a physical, developmental, behavioral, or emotional condition that requires continuity of care, and requests that the infant remain with the current health plan and the sibling(s) remain with his or her current health plan. For siblings enrolled in different health plans, the applicant must choose the same health plan for all children living in the household during the Open Enrollment period after the AIM infant's first birthday.

(2) An AIM infant subscriber shall be transferred from one participating health, dental, or vision plan to another if the applicant so requests in writing once within the first three (3) months from the date of the infant's birth and the infant subscriber has no sibling(s) in the program. The transfer of enrollment shall take effect on the first day of a month and shall be within forty (40) days after the approval of the request but not earlier than the third calendar month of the infant's enrollment in the program.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.326 and 12693.51, Insurance Code.

ARTICLE 3: HEALTH, DENTAL AND VISION BENEFITS

Section 2699.6700 is amended to read:

2699.6700. Scope of Health Benefits.

(a) The basic scope of benefits offered by participating health plans must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975 including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to the exclusions listed in this section and Section 2699.6703. No other benefits shall be permitted to be offered by a participating health plan as part of the program. The basic scope of benefits shall include:

(1) Health Facilities

(A) Inpatient Hospital Services: General hospital services, in a room of two or more, with customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. All ~~medically~~ necessary ancillary services such as: use of operating room and related facilities; intensive care unit and services; drugs, medications, and biologicals; anesthesia and oxygen; diagnostic laboratory and x-ray services; special duty nursing ~~as medically necessary~~; physical, occupational, and speech therapy , respiratory therapy; administration of blood and blood products; other diagnostic, therapeutic and rehabilitative services as appropriate; and coordinated discharge planning, including the planning of such continuing care as may be necessary.

~~Inpatient hospital services. This includes coverage for general anesthesia and associated facility charges, in connection with dental procedures when hospitalization is necessary because of an underlying medical condition or clinical status or because of the severity of the dental procedure. This benefit is only available to subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. Participating health plans shall coordinate such services with the subscriber's participating dental plan. Services of the dentist or oral surgeon are excluded for dental procedures.~~
Exclusions: Personal or comfort items or a private room in a hospital are excluded unless medically necessary.

(B) Outpatient Services: Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility. Includes~~: physical, occupational, and speech therapy as appropriate; and those~~ hospital services which can reasonably be provided on an ambulatory basis~~.~~ and ~~Related~~ related services and supplies in connection with these services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the subscriber's stay at the facility.

Includes physical, occupational, and speech therapy, if necessary.

(C) Inpatient and Outpatient Services include coverage for ~~G~~general anesthesia and associated facility charges, and outpatient services in connection with dental procedures when the use of a hospital or surgery center is necessary because of ~~an underlying~~ the subscriber's medical condition or clinical status or because of the severity of the dental procedure. This benefit is only available to subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Participating health plans shall coordinate such services with the subscriber's participating dental plan. Services of the dentist or oral surgeon for dental procedures are excluded ~~for dental procedures~~.

(2) Professional Services: ~~Medically necessary professional s~~Services and consultations by a physician or other licensed health care provider acting within the scope of his or her license. Includes services of a surgeon ~~Surgery~~, assistant surgeon~~ry~~ and anesthesiologist~~a~~ (inpatient or outpatient); inpatient hospital and skilled nursing facility visits; professional office visits including visits for examinations, allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment; specialist office visits, and home visits ~~when medically necessary. In addition, professional services include:~~.

(3) Preventive Services: Services for the detection and treatment of asymptomatic diseases including:

(A) Vision Services: ~~Eye examinations~~: For subscriber children, vision testing, eye refractions to determine the need for corrective lenses, and dilated retinal eye exams. For subscriber parents, eye refraction is optional for plan. Includes cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery. Also one pair of conventional eyeglasses or conventional contact lenses are covered if necessary after cataract surgery with insertion of an intraocular lens.

(B) Hearing Services: ~~Hearing tests, hearing aids and services~~: Includes hearing testing, an a~~A~~udiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

Hearing Aid: Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Visits for fitting, counseling, adjustments, repairs, etc., at no charge for a one-year period following the provision of a covered hearing aid.

Limitation: For subscriber parents, this benefit is limited to a maximum of $1000 per member every thirty-six months for the hearing instrument and ancillary equipment.

Exclusions: The purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase, ~~and~~ charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss~~.~~ R~~r~~eplacement parts for hearing aids, repair of hearing aid after the covered one-year warranty period, replacement of a hearing aid more than once in any period of thirty-six months, and surgically implanted hearing devices.

(C) Immunizations for Subscriber Children: Immunizations consistent with the most current version of the Recommended Childhood Immunization Schedule/United States adopted by the Advisory Committee on Immunization Practices (ACIP). Includes ~~I~~immunizations required for travel as recommended by the ACIP, and other age appropriate immunizations as recommended by the ACIP.

Immunizations for Subscriber Parents: Immunizations for adults as recommended by the ACIP. Immunizations required for travel as recommended by the ACIP. Immunizations such as Hepatitis B for individuals at occupational risk, and other age appropriate immunizations as recommended by the ACIP.

(D) Periodic Health Examinations: For subscriber children, periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventative Pediatric Health Care, as adopted by the American Academy of Pediatrics; ~~and the most current version of the Recommended Childhood Immunization Schedule/United States, adopted by the Advisory Committee on Immunization Practices (ACIP).~~

The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the subscriber including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

Periodic Health Examinations for Subscriber Parents: Periodic health examinations including all routine diagnostic testing and laboratory services appropriate for such examinations. This includes coverage for the screening and diagnosis of prostate cancer including but not limited to, prostate-specific antigen testing and digital rectal examination, when medically necessary and consistent with good medical practice. The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the subscriber including a subscriber's desire for physical examinations, or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

(E) Well Baby Care during the first two years of life, including newborn hospital visits, health examinations and other office visits.

(F) Family Planning Services: Voluntary family planning services including, counseling and surgical procedures for sterilization as permitted by state and federal law, diaphragms, and coverage for other federal Food and Drug Administration approved devices and contraceptive drugs pursuant to the prescription drug benefit.

(G) Maternity Services: Professional and hospital services relating to maternity care including pre-natal and postpartum care and complications of pregnancy, prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy, labor and delivery care, newborn examinations and nursery care while the mother is hospitalized, and coverage for participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program.

(H) Sexually Transmitted Disease (STD) Testing and Treatment.

(I) Health Education Services: Includes information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services. Includes diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable a subscriber to properly use equipment and supplies provided for the management and treatment of insulin-using diabetes, non-insulin using diabetes, and gestational diabetes.

(J) Cytology Examinations on a reasonable periodic basis.

(K) Gynecological Examinations: Yearly pelvic examination, Pap smear, breast exam, and any other gynecological service as appropriate.

(L) Cancer Screening: Medically accepted cancer screening tests including, but not limited to, breast, prostate, and cervical cancer screening.

(~~3~~4) Diagnostic ~~X-ray and~~ Laboratory Services: Diagnostic laboratory services, diagnostic imaging, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat, and follow-up on the care of subscribers. Other diagnostic services, which shall include, but not be limited to, electrocardiography, electro-encephalography, and mammography for screening or diagnostic purposes. Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin).

(4~~5~~) Prescription Drugs: ~~Medically necessary d~~Drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes injectable medication, and needles and syringes necessary for the administration of the covered injectable medication.

~~Also includes i~~Insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin, blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, noninsulin dependent and gestational diabetes.

Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins require a prescription.

All FDA approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered including internally implanted time release contraceptives.

One cycle or course of treatment of tobacco cessation drugs per benefit year. The health plan must also require the subscriber to attend tobacco use cessation classes or programs in conjunction with tobacco cessation drugs.

For subscriber parents, plans can require subscribers to pay a portion or all the cost of the smoking cessation classes or programs. Plans can also require the subscriber parent to pay the cost of the smoking cessation drug initially and reimburse the subscriber parent minus the copayment(s) upon the successful completion of a smoking cessation program.

~~Medically necessary d~~Drugs administered while a subscriber is a patient or resident in a rest home, nursing home, convalescent hospital or similar facility when prescribed by a plan physician in connection with a covered service and obtained through a plan designated pharmacy.

Health plans may specify that generic equivalent prescription drugs must be dispensed if available, provided that no medical contraindications exist. The use of a formulary, maximum allowable

cost (MAC) method, and mail order programs by health plans is encouraged.

~~Health plans shall provide coverage for one cycle or course of treatment of tobacco cessation drugs per benefit year. The health plan must also require the subscriber to attend tobacco use cessation classes or programs in conjunction with tobacco cessation drugs.~~

~~For subscriber parents, plans can require subscribers to pay a portion or all the cost of the smoking cessation classes or programs. Plans can also require the subscriber parent to pay the cost of the smoking cessation drug initially and reimburse the subscriber parent minus the copayment(s) upon the successful completion of a smoking cessation program.~~

~~Contraceptive Drugs and Devices: All FDA approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered including internally implanted time release contraceptives such as Norplant.~~

Exclusions: Experimental or investigational drugs~~, unless accepted for use by the standards of the medical community~~; drugs or medications prescribed solely for cosmetic purposes; patent or over-the-counter medicines, including nonprescription contraceptive jellies, ointments, foams, condoms, etc., even if prescribed by a doctor; medicines not requiring a written prescription order (except insulin and smoking cessation drugs as previously described); and dietary supplements (except for formulas or special food products to treat phenylketonuria or PKU)~~,~~; and appetite suppressants or any other diet drugs or medications~~.~~, unless necessary for the treatment of morbid obesity.

(~~5~~6) Durable Medical Equipment: Medical equipment appropriate for use in the home which: 1) is intended for repeated use; 2) is generally not useful to a person in the absence of illness or injury; and 3) primarily serves a medical purpose. The health plan may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Includes ~~O~~oxygen and oxygen equipment; blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non-insulin dependent, and gestational diabetes; insulin pumps and all related supplies; visual

aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin~~,~~; ~~and~~ apnea monitors; podiatric devices to prevent or treat diabetes complications; pulmoaides and related supplies; nebulizer machines, face masks, tubing and related supplies, peak flow meters and spacer devices for metered dose inhalers; ostomy bags and urinary catheters and supplies.

Exclusions: Coverage for comfort or convenience items; disposable supplies except ostomy bags and urinary catheters and supplies consistent with Medicare coverage guidelines; exercise and hygiene equipment; experimental or research equipment; devices not medical in nature such as sauna baths and elevators, or modifications to the home or automobile; deluxe equipment; or more than one piece of equipment that serve the same function.

(~~6~~7) Orthotics and Prosthetics: Orthotics and prosthetics including ~~medically necessary~~ replacement prosthetic devices ~~as prescribed by a licensed practitioner acting within the scope of his or her licensure~~, and ~~medically necessary~~ replacement orthotic devices when prescribed by a licensed provider ~~practitioner~~ acting within the scope of his or her licensure. Coverage for the initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear for diabetics. Also includes prosthetic devices to restore and achieve symmetry incident to mastectomy.

Exclusions: Corrective shoes and arch supports, except for therapeutic footwear and inserts for individuals with diabetes; non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts; dental appliances; electronic voice producing machines; or more than one device for the same part of the body. Also does not include eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery).

~~(7) Cataract Spectacles and Lenses: Cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered. Also one pair of conventional eyeglasses or conventional contact lenses are covered if necessary after cataract surgery with insertion of an intraocular lens.~~

~~(8) Maternity: Medically necessary professional and hospital services relating to maternity care including: pre-natal and post-natal care~~

~~and complications of pregnancy; newborn examinations and nursery care while the mother is hospitalized Includes providing coverage for participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program.~~

~~(9) Family Planning: Voluntary family planning services including counseling and surgical procedures for sterilization as permitted by state and federal law, diaphragms, and coverage for other federal Food and Drug Administration approved devices and contraceptive drugs pursuant to the prescription drug benefit.~~

(~~10~~8) Medical Transportation Services: Emergency ambulance transportation in connection with emergency services to the first hospital which actually accepts the subscriber for emergency care. Includes ambulance and ambulance transport services provided through the "911" emergency response system.

Non-emergency transportation for the transfer of a subscriber from a hospital to another hospital or facility or facility to home when the transportation is:

(A) Medically necessary, and

(B) Requested by a plan provider, and

(C) Authorized in advance by the participating health plan.

Exclusions: Coverage for public transportation, including transportation by airplane, passenger car, taxi or other form of public conveyance.

(~~11~~9) Emergency Health Care Services: Twenty-four hour emergency care for a medical or psychiatric condition, including active labor or severe pain, ~~condition~~ manifesting itself by acute symptoms of a sufficient severity ~~(including severe pain)~~ such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(A) Serious jeopardy to ~~Placing~~ the patient's health ~~in serious jeopardy~~, or~~.~~

(B) Serious impairment to bodily functions, or~~.~~

(C) Serious dysfunction of any bodily organ or part.

Coverage ~~This~~ must be provided both inside and outside of the health plan's service area and in ~~and out of the health plan's~~ participating and non-participating facilities.

(~~12~~10) Mental Health

(A) Inpatient: Mental health care during a certified confinement in a participating hospital when ordered and performed by a participating mental health provider ~~professional~~ for the treatment of a mental health condition. For subscriber children determined by their county mental health department to meet the criteria for Serious Emotional Disturbances (SED) of a child or for a serious mental disorder, pursuant to Section 5600.3 of the Welfare and Institutions Code, plans may limit services to 30 days per benefit year.

Plans shall be responsible for identifying subscriber children who may ~~be SED~~ have a Serious Emotional Disturbances (SED) condition, as defined in California Health and Safety Code section 1374.72, or may have a serious mental disorder, as defined in Welfare and Institutions Code section 5600.3, and shall refer these individuals to their respective county mental health department for evaluation ~~determination~~. For subscriber children who are determined ~~as~~ to have a SED condition or ~~as having~~ a serious mental disorder by their county mental health department, participating plans shall provide up to 30 days of inpatient care, including related professional services. After 30 days, the responsibility for providing inpatient and related professional services for continued treatment of the condition will transfer to the county mental health department. The plan and the county shall coordinate services for the subscriber. ~~and shall then refer these individuals to their county mental health department for continued treatment of the condition.~~

Except as limited pursuant to the previous paragraph for subscribers who are determined ~~as~~ to have a SED condition or ~~as having~~ a serious mental disorder by their county mental health department, plans must provide services with

no ~~visit~~ inpatient day limits for severe mental illnesses including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

Plans may limit inpatient coverage to 30 days per benefit year for illnesses that meet neither the criteria for severe mental illnesses~~,~~ nor the criteria for SED of a child or for a serious mental disorder ~~pursuant to Section 5600.3 of the Welfare and Institutions Code~~.

Plans, with the agreement of the subscriber or applicant or other responsible adult if appropriate, may substitute for each day of inpatient hospitalization any of the following: two (2) days of residential treatment, three (3) days of day care treatment, or four (4) outpatient visits.

(B) Outpatient: Mental health care when ordered and performed by a participating mental health provider ~~professional~~. This includes the treatment of children who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, or divorce and bereavement. Family members may be involved in the treatment to the extent the plan determines it is appropriate for the health and recovery of the child.

Plans must provide services with no visit limits for severe mental illnesses, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulimia nervosa.

Plans shall be responsible for identifying subscriber children who may ~~be SED~~ have a Serious Emotional Disturbances (SED) condition, as defined in California Health and Safety Code section 1374.72, or may have a serious mental disorder, as defined in Welfare and Institutions Code section 5600.3, and shall refer these individuals to their county mental health department for evaluation ~~determination~~. Notwithstanding the first sentence of ~~this~~ the previous paragraph, participating plans shall refer subscriber children

who are determined by their county mental health department ~~as~~ to have a SED or ~~as having~~ a serious mental disorder ~~pursuant to Section 5600.3 of the Welfare and Institutions Code~~, to their county mental health department for treatment of the condition. For subscriber children who are determined to have a SED condition or a serious mental disorder by their county mental health department, outpatient and related professional services pertaining to the condition will be provided by the county mental health department. The plan and the county shall coordinate services for the subscriber.

Plans must provide up to at least 20 visits per benefit year ~~Plans may limit coverage to 20 days per benefit year~~ for illnesses that meet neither the criteria for severe mental illnesses, nor the criteria for SED of a child or a serious mental disorder ~~pursuant to Section 5600.3 of the Welfare and Institutions Code~~.

Participating plans may elect to provide additional visits. Plans may provide group therapy at a reduced copayment.

(~~13~~11) Alcohol and Drug Abuse Services:

(A) Inpatient: Hospitalization for alcoholism or drug abuse ~~as medically appropriate~~ to remove toxic substances from the system.

(B) Outpatient: Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis ~~as medically appropriate.~~

Participating health plans shall provide ~~offer~~ at least 20 visits per benefit year. Participating health plans may elect to provide additional visits.

(~~14~~12) Home Health Services: Health services provided at the home by health care personnel. Includes visits by Registered Nurses, Licensed Vocational Nurses, and home health aides; physical, occupational and speech therapy; and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure.

Home health services are limited to those services that are prescribed or directed by the attending physician or other appropriate authority designated by the plan. If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority designated by the plan to choose the setting for providing the care. Plans shall exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting. Medical case management may include consideration of whether a particular service or setting is cost-effective when there is a choice among several medically appropriate alternative services or settings.

Exclusions: Custodial care

(~~15~~13) Skilled Nursing Care: Services prescribed by a plan physician or nurse practitioner and provided in a licensed skilled nursing facility ~~when medically necessary~~. Includes ~~S~~skilled nursing on a 24-hour per day basis; bed and board; x-ray and laboratory procedures; respiratory therapy; physical, occupational and speech therapy; medical social services; prescribed drugs and medications; medical supplies; and appliances and equipment ordinarily furnished by the skilled nursing facility. This benefit shall be limited to a maximum of 100 days per benefit year.

Exclusions: Custodial care.

(~~16~~14) Physical, Occupational, and Speech Therapy: Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility or home. Plans may require periodic evaluations as long as therapy~~, which is medically necessary,~~ is provided.

(~~17~~15) Acupuncture and Chiropractic: These are optional benefits which plans may offer. If offered, the plan must provide a self referral benefit, and cannot require referral from a primary care or other physician or health professional. ~~For subscribers, c~~Coverage is limited to a maximum of 20 visits each per benefit year ~~for acupuncture and chiropractic~~. Plans may provide a combined chiropractic/ acupuncture benefit with a minimum of 20 visits allowed for both disciplines.

(~~18~~16) Biofeedback is an optional benefit which health plans may offer.

(~~19~~17) Blood and Blood Products: Processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Includes the collection and storage of autologous blood when medically indicated.

~~(20) Health Education: Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan~~.

(~~21~~18) Hospice: ~~The hospice benefit shall include nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services., The benefit shall also include physical therapy, occupational therapy, speech therapy, short-term inpatient care, pain control, and symptom management.~~ The hospice benefit is ~~limited to those individuals~~ provided to subscribers who are diagnosed with a terminal illness with a life expectancy of twelve months or less and who elect hospice care for such illness instead of the traditional services by the plan.

The hospice benefit shall include nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services~~.~~, ~~The benefit shall also include~~ physical therapy, occupational therapy, speech therapy, short-term inpatient care, pain control, and symptom management.

The hospice benefit may include, at the option of the health plan, homemaker services, services of volunteers, and short-term inpatient respite care.

~~The hospice benefit is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of twelve months or less and who elect hospice care for such illness instead of the traditional services covered by the plan.~~

Individuals who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect. The hospice election may be revoked at any time.

(~~22~~19) Transplants: Coverage for ~~medically necessary~~ organ transplants and bone marrow transplants which are not experimental or investigational ~~in nature~~. Includes ~~R~~reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a subscriber.

Charges for testing of relatives for matching bone marrow transplants.

Charges associated with the search and testing of unrelated bone marrow donors through a recognized Donor Registry and charges associated with the procurement of donor organs through a recognized Donor Transplant Bank, if the expenses are directly related to the anticipated transplant of a subscriber.

(~~23~~20) Reconstructive Surgery: ~~Reconstructive s~~Surgery to restore and achieve symmetry and surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following:

(A) Improve function

(B) Create a normal appearance to the extent possible Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

(21) Clinical Trial for Cancer Patients: Coverage for a subscriber's participation in a clinical trial when the subscriber has been diagnosed with cancer and has been accepted into a phase I through phase IV clinical trial for cancer, and the subscriber's treating physician recommends participation in the clinical trial after determining that participation will have a meaningful potential to benefit the subscriber. Coverage includes the payment of costs associated with the provision of routine patient care, including drugs, items, devices and services that would otherwise be covered if they were not provided in connection with an approved clinical trial program; services required for the provision of the investigational drug, item, device or service; services required for the clinically appropriate monitoring of the investigational drug, item, device, or service; services provided for the prevention of

complications arising from the provision of the investigational drug, item, device, or service; and services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis or treatment of complications.

Exclusions: Provisions of non-FDA-approved drugs or devices that are the subject of the trial; services other than health care services, such as travel, housing, and other non-clinical expenses that a member may incur due to participation in the trial; any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient; services that are otherwise not a benefit (other than those excluded on the basis that they are investigational or experimental); and services that are customarily provided by the research sponsors free of charge for any enrollee in the trial. Coverage for clinical trials may be restricted to participating hospitals and physicians in California, unless the protocol for the trial is not provided in California.

(22) Phenylketonuria (PKU): Testing and treatment of PKU, including those formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease, provided that the diet is deemed necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

(~~24~~23) Participating health plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS Program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating health plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS Program.

(~~25~~24) Participating health plans shall be responsible for identifying subscriber children who are severely emotionally disturbed and

shall refer these individuals to their county mental health department for continued treatment of the condition.

(b) This part shall not be construed to prohibit a plan's ability to impose cost-control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing benefits in alternative settings or using alternative methods.

(c) (1) The scope of benefits shall include all benefits which are covered under the California Children's Services (CCS) Program (Health and Safety Code Section 123800, et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber under the age of 21 is determined by the CCS Program to be eligible for benefits under that program, a participating health plan shall not be responsible for the provision of, or payment for, the particular services authorized by the CCS Program for the particular subscriber for the treatment of CCS eligible medical condition. All other services provided under the participating health plan shall be available to the subscriber.

(d) (1) The scope of benefits shall include benefits provided by a county mental health department to a subscriber child the department has determined is seriously emotionally disturbed or has a serious mental disorder pursuant to Section 5600.3 of the Welfare and Institutions Code.

(2) When a subscriber child is determined by a county mental health department to be seriously emotionally disturbed or to have a serious mental disorder pursuant to Section 5600.3 of the Welfare and Institutions Code, the participating health plan shall not be responsible for the provision of, or payment for, services provided by the county mental health department. This does not relieve the participating health plan from providing the mental health coverage specified in Section 2699.6700(a)(10~~12~~).

(e) If, pursuant to any Workers' Compensation, Employer's Liability Law, or other legislation of similar purpose or import, benefits are provided or payable or payable to treat any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain, the participating health plan shall provide the services at the time of need, and the subscriber or applicant shall

cooperate to assure that the participating health plan is reimbursed for such services.

(f) Coverage provided under the Healthy Families Program is secondary to all other coverage, except Medi-Cal. Benefits paid under this Program are determined after benefits have been paid as a result of a subscriber's enrollment in any other health care program. If medical services are eligible for reimbursement by insurance or covered under any other insurance or health care service plan, the participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such services.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.60, 12693.61, 12693.62 and 12693.755, Insurance Code.

Section 2699.6703 is amended to read:

2699.6703. Excluded Health Benefits.

(a) Health benefit plans offered under this program shall exclude all of the following:

(1) Any ~~services or items~~ benefits specified as excluded within Section 2699.6700.

(2) Any benefits in excess of limits specified in Section 2699.6700.

(3) Services, supplies, items, procedures or equipment, which are not medically necessary as determined by the plan, unless otherwise specified in Section 2699.6700.

(4) Any benefits that ~~services which~~ are received prior to the subscriber's effective date of coverage. This exclusion does not apply to covered benefits to treat complications arising from services received prior to the subscriber's effective date of coverage.

(5) Any benefits that are received subsequent to the time the subscriber's coverage ends.

~~(5) Those medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices which are either:~~

~~(A) Experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question, or~~

~~(B) Outmoded or not efficacious.~~

(6) Experimental or investigational services, including any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards, or for which the safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed.

(~~6~~7) ~~Emergency facility services for non-emergency conditions.~~ Medical services that are received in an emergency care setting for conditions that are not emergencies if the subscriber reasonably should have known that an emergency care situation did not exist.

(~~7~~8) Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery which are covered under Subsection 2699.6700(a)(~~7~~3)(A).

(~~8~~9) ~~Treatment for infertility is excluded.~~ The ~~D~~diagnosis and treatment of infertility ~~for subscribers~~ is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.

(~~9~~10) Long-Term Care Benefits including long-term skilled nursing care in a licensed facility and respite care are excluded except as a participating health plan shall determine they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided pursuant to Subsection 2699.6700 (a)(~~15~~13) and (a)(~~2~~18).

~~(10) Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation,~~

~~profit or gain for which benefits are provided or payable under any Worker's Compensation benefit plan. The participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such benefits.~~

~~(11) Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. The participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such benefits.~~

(~~12~~11) Cosmetic surgery that is solely performed to alter or reshape normal structures of the body in order to improve appearance.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.60 and 12693.755, Insurance Code.

Section 2699.6705 is amended to read:

2699.6705. Share of Cost for Health Benefits.

(a) Every participating health plan shall require copayments for benefits provided to subscribers, except as provided under federal law to subscribers who are American Indians receiving services at an Indian Health Service Facility, subject to the following:

(1) In any benefit year that the applicant has incurred $250 in health benefit copayments for services received by subscribers who live in one household and for whom the applicant applied to the program, the applicant shall be deemed to have met the copayment maximum.

(2) No deductibles shall be charged to subscribers for health benefits.

(3) The following specific copayments shall apply:

(A) Inpatient Facility Services provided in a licensed hospital, skilled nursing facility, hospice, or mental health facility: No copayment.

(B) Inpatient Professional Services provided in a licensed hospital, skilled nursing facility, hospice, or mental health facility: No copayment.

(C) Facility Services on an Outpatient Basis for Subscribers: No copayment, except for a $5 copayment per visit for Emergency Health Care Services. The emergency health care services copay is waived if the subscriber is hospitalized.

(D) Outpatient Professional Services: $5 copayment per office or home visit. No copayment for surgery or anesthesia; radiation, chemotherapy, or dialysis treatments.

(E) Outpatient Mental Health: $5 copayment per visit.

(F) Home Health Care: No copayment except for $5 per visit for physical, occupational, and speech therapy visits performed in the home.

(G) Alcohol and Drug Abuse Services: No copayment for inpatient services. $5 per visit for outpatient services.

(H) Hospice: No copayment for any services provided under this benefit.

(I) Transplants: No copayment for any services provided under this benefit.

(J) Physical, Occupational, and Speech Therapy: No copayment for therapy performed on an inpatient basis. $5 copayment per visit for therapy performed in the home or other outpatient setting.

(K) Biofeedback, Acupuncture, and Chiropractic Visits, when offered at the participating health plan's option: $5 copayment per visit. For subscriber parents, copayment of $5 for each biofeedback visit for mental health.

(L) Diagnostic Laboratory Services, diagnostic and therapeutic radiological services, and other diagnostic services; durable medical equipment, prosthetics and orthotics; blood and

blood products; medical transportation services: No copayment.

~~(M) Hearing Aids: No copayment.~~

(~~N~~M) Prescription Drugs: No copayment for prescription drugs provided in an inpatient setting, or for drugs administered in the doctor's office or in an outpatient facility setting during the subscriber's stay at the facility. ~~$5 per prescription for up to a 30-34 day supply for brand name or generic drugs, including tobacco use cessation drugs~~. For subscriber children, no copayment for FDA approved contraceptive drugs ~~and devices including Norplant~~.

$5 copayment per prescription for up to 30~~-34~~ day supply for brand name or generic drugs, including tobacco use cessation drugs. $5 copayment per 90~~-100~~ day supply of maintenance drugs purchased either through a participating health plan's participating pharmacies or through its mail order program. Maintenance drugs are drugs that are prescribed for 60 days or longer and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.

For subscriber parents, $5 copayment for 90 day supply of FDA approved oral and injectable contraceptives and contraceptive devices. No refund if the medication is removed. (Represents the copayment for oral contraceptives at $5 copay for each 90-day supply for the approximate number of months the medication will be effective).

~~Maintenance drugs: $5 copayment per 90-100 day supply either through a participating health plan's participating pharmacies or through its mail order program. Maintenance drugs are drugs that are prescribed for 60 days or longer and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.~~

(4) Preventive services~~, including services for the detection of asymptomatic diseases, as defined by applicable Department of Managed Health Care regulations. These include:~~

(A) Periodic Health Exams; No copayment for subscriber children; $5 copayment per exam for subscriber parents.

(B) A variety of voluntary family planning services; including contraceptive services~~,~~: No copayment for subscriber children. For subscriber parents $5 copayment per office visit and $5 copayment per device.

~~Contraceptive services – no copayment for subscriber children. $5 copayment per visit and $5 copayment per device for subscriber parents.~~

(C) ~~Prenatal care;~~ Maternity Services: No copayment.

(D) Vision Services: ~~and hearing testing;~~ No copayment for subscriber children. For subscriber parents, $5 copayment per visit.

Eye refraction to determine the need for corrective lenses- No copayment for subscriber children. For subscriber parents, optional with $5 copayment per exam and limited to one visit per year.

(E) Hearing Services and Hearing Aids: No copayment.

(~~E~~F) Immunizations; No copayment for subscriber children. $5 copayment per visit for subscriber parent.

(~~F~~G) Sexually Transmitted Disease Testing: ~~Venereal disease tests;~~ No copayment for subscriber children. $5 copayment for subscriber parents.

(~~G~~H) Cytology Examinations on a reasonable periodic basis~~;~~ No copayment for subscriber children. For subscriber parents, $5 copayment per exam.

(~~H~~I) ~~Effective h~~Health Education Services~~:, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the participating health plan or health care organizations affiliated with the participating health plan.~~ No copayment for subscriber children.

For subscriber parents, up to $5 copayment for diabetes outpatient self-management training, education, and medical nutrition therapy services. Charge may vary for other education services.

~~(5)~~ (J) Well Baby Care, Health Examinations and Other Office Visits ~~No copayment shall be charged to~~ for subscribers ~~under~~ 24 months of age and under: ~~for well baby care, health examinations and other office visits~~ No copayment.

(K) Gynecological Examinations and Cancer Screening: No copayment.

(~~6~~5) No copayments shall apply if the applicant has submitted acceptable documentation as described in Subsection 2699.6600(c)(1)(GG) that the applicant or the subscriber is American Indian or Alaska Native.

(~~7~~6) Reconstructive Surgery: – No copayment

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.615 and 12693.755, Insurance Code.

Section 2699.6709 is amended to read:

2699.6709. Scope of Dental Benefits for Subscriber Children.

(a) The basic scope of benefits offered by a participating dental plan must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to the exclusions listed in Section 2699.6713.

The covered dental benefit is limited to the benefit level for the least costly dentally appropriate alternative. If a more costly, optional alternative is chosen by the applicant, the applicant will be responsible for all charges in excess of the covered dental benefit.

No other dental benefits ~~for subscriber children~~ shall be permitted to be offered by a participating dental plan as part of the program. The basic scope of dental benefits shall be as follows:

(1) Diagnostic and Preventive Benefits

(A) Initial and periodic oral examinations.

(B) Consultations, including specialist consultations.

(C) Roentgenology, limited as follows:

1. Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

2. Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.

3. Panoramic film x-rays are limited to once every 24 consecutive months.

(D) Prophylaxis services, limited as follows: Not to exceed two in a twelve month period.

(E) Topical fluoride treatment.

(F) Dental sealant treatments, limited as follows: Permanent first and second molars only.

(G) Space maintainers, including removable acrylic and fixed band type.

(H) Preventive dental education and oral hygiene instruction.

(2) Restorative Dentistry

(A) Restorations, limited as follows:

1. Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional.

2. Composite resin or acrylic restorations in posterior teeth are optional.

3. Micro filled resin restorations which are noncosmetic.

4. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

(B) Use of pins and pin build-up in conjunction with a restoration.

(C) Sedative base and sedative fillings.

(3) Oral Surgery

(A) Extractions, including surgical extractions

(B) Removal of impacted teeth, limited as follows: Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

(C) Biopsy of oral tissues

(D) Alveolectomies

(E) Excision of cysts and neoplasms

(F) Treatment of palatal torus

(G) Treatment of mandibular torus

(H) Frenectomy

(I) Incision and drainage of abscesses

(J) Post-operative services including exams, suture removal and treatment of complications

(K) Root recovery (separate procedure)

(4) Endodontics

(A) Direct pulp capping

(B) Pulpotomy and vital pulpotomy

(C) Apexification filling with calcium hydroxide

(D) Root amputation

(E) Root canal therapy, including culture canal, and retreatment of previous root canal therapy limited as follows: Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

(F) Apicoectomy

(G) Vitality tests

(5) Periodontics

(A) Emergency treatment, including treatment for periodontal abscess and acute periodontitis.

(B) Periodontal scaling and root planing, and subgingival curettage, limited as follows: Five quadrant treatments in any 12 consecutive months.

(C) Gingivectomy

(D) Osseous or muco-gingival surgery

(6) Crowns and Fixed Bridges

(A) Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are limited as follows:

1. Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the dental plan.

2. Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.

3. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

4. Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

(B) Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:

1. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.

2. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. Under the age of 16, it is considered optional dental treatment. If performed on a subscriber under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.

3. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.

4. Fixed bridges are optional when provided in connection with a partial denture on the same arch.

5. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

(C) The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction which is optional treatment.

(D) Recementation of crowns, bridges, inlays and onlays.

(E) Cast post and core, including cast retention under crowns.

(F) Repair or replacement of crowns, abutments or pontics.

(7) Removable Prosthetics

(A) Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, limited as follows:

1. Partial dentures are not to be replaced within 36 consecutive months, unless:

a. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or

b. The denture is unsatisfactory and cannot be made satisfactory.

2. The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.

3. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.

4. Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.

5. The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the applicant will be responsible for all additional charges.

(B) Office or laboratory relines or rebases, limited as follows:

One per arch in any 12 consecutive months.

(C) Denture repair.

(D) Denture adjustment.

(E) Tissue conditioning, limited to two per denture.

(F) Denture duplication.

(G) Implants are considered an optional benefit.

(H) Stayplates, limited as follows: Stayplates are a benefit only when used as anterior space maintainers for children.

(8) Orthodontic Treatment, limited as follows: If the subscriber child meets the eligibility requirements for medically necessary orthodontia coverage under the California Children's Services program, benefits shall be provided and determined by the California Children's Services program.

(9) Other Dental Benefits

(A) Local anesthetics.

(B) Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(C) Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(D) Emergency treatment, palliative treatment.

(E) Coordination of benefits with subscriber's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services.

(10) This part shall not be construed to prohibit a dental plan's ability to impose cost control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing alternative treatments or services.

(11) Participating dental plans shall be responsible for identifying subscribers ~~under the age of 21~~ who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS Program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating dental plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.

(b) (1) The scope of dental benefits shall also include all dental benefits which are covered under the California Children's Services program (Health and Safety Code Section 123800 et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber ~~under the age of 21~~ is determined by the California Children's Services Program (Health and Safety Code Section 123800 et seq.) to be eligible for benefits under that program, a participating dental plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating dental plan shall be available to the subscriber.

(c) If, pursuant to any Workers' Compensation, Employer's Liability Law, or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of dental services to treat any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain, the participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating dental plan is reimbursed for such services.

(d) Coverage provided under the Healthy Families Program is secondary to all other coverage, except Denti-Cal. Benefits paid under this Program are determined after benefits have been paid as a result of a subscriber's enrollment in any other dental care program. If dental services are eligible for reimbursement by insurance or covered under any other insurance or dental care service plan, the participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating dental plan is reimbursed for such services.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.63~~,~~ and 12693.64 ~~and 12693.755~~, Insurance Code.

Section 2699.6711 is amended to read:

2699.6711. Scope of Dental Benefits for Subscriber Parents.

(a) The basic scope of benefits offered by a participating dental plan must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to certain exclusions as listed in Section 2699.6713.

The covered dental benefit is limited to the benefit level for the least costly dentally appropriate alternative. If a more costly, optional alternative is chosen by the applicant, the applicant will be responsible for all charges in excess of the covered dental benefits.

No other dental benefits shall be permitted to be offered by a participating dental plan as part of the program. The basic scope of dental benefits shall be as follows:

(1) Diagnosis and Preventive Benefits

(A) Initial and periodic oral examinations – oral examinations are benefits only twice in a benefit year.

(B) Consultations, including specialist consultations

(C) Roentgenology, limited as follows:

1. Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in a benefit year.

2. Full mouth x-rays in conjunction with periodic examinations are limited to once in a three-year period unless special need is shown.

3. Panoramic film x-rays are limited to once in a three year period.

(D) Prophylaxis Services, not to exceed two in a twelve month period.

A third cleaning will be provided as a benefit for high-risk patients in the following categories:

1. Women who are pregnant

2. Subscribers undergoing cancer chemotherapy

3. Subscribers with compromising systemic diseases such as diabetes as determined to be medically necessary for appropriate dental care by the provider and approved by the plan.

(E) Space maintainers, including removable acrylic and fixed band type.

(F) Preventive dental education and oral hygiene instructions

(2) Restorative Dentistry ~~– amalgam, synthetic, plastic or resin restorations (fillings) for treatment of cavities (decay)~~

(A) Restorations, limited as follows:

1. Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional.

2. Composite resin or acrylic restorations in posterior teeth are optional.

3. Micro filled resin restorations which are non-cosmetic.

4. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

(B) Use of pins and pin build-up in conjunction with a restoration.

(C) Sedative base and sedative fillings.

(3) Oral Surgery~~-extractions and certain other surgical procedures, including pre-and post-operative care.~~

(A) Extractions, including surgical extractions.

(B) Removal of impacted teeth. Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

(C) Biopsy of oral tissues

(D) Alveolectomies

(E) Excision of cysts and neoplasms

(F) Treatment of palatal torus

(G) Treatment of mandibular torus

(H) Frenectomy

(I) Incision and drainage of abscesses

(J) Post-operative services including exams, suture removal and treatment of complications.

(K) Root recovery (separate procedure)

(4) Endodontics ~~– treatment of tooth pulp~~

(A) Direct pulp capping

(B) Pulpotomy and vital pulpotomy

(C) Apexification filling with calcium hydroxide

(D) Root amputation

(E) Root canal therapy, including culture canal, and retreatment of previous root canal therapy limited as follows.

Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology is not a covered benefit.

(F) Apicoectomy

(G) Vitality tests

(5) Periodontics ~~– treatment of gums and bones that support the teeth~~

(A) Emergency treatment, including treatment for periodontal abscess and acute periodontitis.

(B) Periodontal scaling and root planing, and subgingival curettage, limited as follows: Five quadrant treatments in any 12 consecutive months.

(C) Gingevectomy

(D) Osseous or Muco-Gingival Surgery. ~~Periodontal procedures which include cleanings are subject to the same limitations as other cleanings i.e., cleaning of any kind are benefits no~~

~~more than twice in a benefit year except for high-risk patients as described in (a)(1)(D)1.~~

(E) Periodontal procedures which include cleanings are subject to the limitations described in Subsection 2699.6711(a)(1)(D).

(6) Crown, Jackets, Cast and Fixed Bridges ~~— crowns, jackets and cast restorations are benefits only if they are provided to treat cavities that cannot be restored with amalgam, synthetic plastic or resin fillings.~~

(A) Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are limited as follows:

1. Replacement of each unit is limited to once every five years.

2. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

3. Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

(B) Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:

1. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.

2. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth and the patient’s oral health and general dental condition permits.

3. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.

4. Fixed bridges are optional when provided in connection with a partial denture on the same arch.

5. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

(C) The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction which is an optional treatment.

(D) Recementation of crowns, bridges, inlays and onlays.

(E) Cast post and core, including cast retention under crowns.

(F) Repair or replacement of crowns, abutments or pontics.

(7) Removable Prosthetics

(A) Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, limited as follows:

1. Partial dentures are not to be replaced within five years unless:

a. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, there has been such an extensive loss of remaining teeth, or a change in supporting tissues, or

b. The denture is unsatisfactory and cannot be made satisfactory.

2. The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by

the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.

3. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.

4. Full upper and/or lower dentures are not to be replaced within five years unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair, the plan determines that there has been such an extensive loss of remaining teeth, or a change in supporting tissue that the existing appliance cannot be made satisfactory.

5. The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. The plan will pay the applicable percentage of the dentist's fee for a standard partial or complete denture up to a maximum fee allowance (or established UCR fee). If a more personalized or specialized treatment is chosen by the patient and the dentist, the applicant will be responsible for all additional charges.

(B) Office or laboratory relines or rebases, limited to one per arch in any 12 consecutive months.

(C) Denture Repair

(D) Denture adjustment

(E) Tissue conditioning, limited to two per denture

(F) Denture duplication

(G) Implants (appliances inserted into bone or soft tissue in the jaw usually to anchor a denture) are covered.

(H) Stayplates – provided as a benefit only when used to replace extracted anterior teeth for adults during a healing period.

(8) Other Dental Benefits

(A) Local anesthetics

(B) Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(C) Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(D) Emergency treatment, palliative treatment.

(E) Coordination of benefits with subscriber's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services.

(9) This part shall not be construed to prohibit a dental plan's ability to impose cost control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing alternative treatments or services.

(10) Participating dental plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS Program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating dental plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.

(b) (1) The scope of dental benefits shall also include all dental benefits which are covered under the California Children's Services program (Health and Safety Code Section 123800 et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber under the age of 21 is determined by the California Children's Services Program (Health and Safety Code Section 123800 et seq.) to be eligible for benefits under that program, a participating dental plan shall not be responsible for the

provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating dental plan shall be available to the subscriber.

(c) If, pursuant to any Workers' Compensation, Employer's Liability Law, or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of dental services to treat any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain, the participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating dental plan is reimbursed for such services.

(d) Coverage provided under the Healthy Families Program is secondary to all other coverage, except Denti-Cal. Benefits paid under this Program are determined after benefits have been paid as a result of a subscriber's enrollment in any other dental care program. If dental services are eligible for reimbursement by insurance or covered under any other insurance or dental care service plan, the participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating dental plan is reimbursed for such services.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.63, 12693.64 and 12693.755, Insurance Code

Section 2699.6713 is amended to read:

2699.6713. Excluded Dental Benefits for All Subscribers.

(a) A dental benefits plan offered under this program shall exclude:

(1) Any benefits specified as excluded within Section 2699.6709 or Section 2699.6711.

(2) Any benefits in excess of limits specified in Section 2699.6709 or Section 2699.6711.

(3) Services, supplies, items, procedures or equipment, which are not medically necessary as determined by the plan, unless otherwise specified in Section 2699.6709 or Section 2699.6711.

(4) Any benefits received or costs that were incurred in connection with any dental procedures started prior to the subscriber's effective date of coverage. This exclusion does not apply to covered services to treat complications arising from services received prior to the subscriber's effective date of coverage.

(5) Any benefits that are received subsequent to the time the subscriber's coverage ends.

(6) Experimental or investigational services, including any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards, or for which the safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed.

(7) Dental services that are received in an emergency care setting for conditions that are not emergencies if the subscriber reasonably should have known that an emergency care situation did not exist.

~~(1) Services which, in the opinion of the attending dentist, are not necessary to the subscriber's dental health.~~

(~~2~~8) Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in Section 2699.6709 ~~and~~ or Section 2699.6711.

(~~3~~9) Cosmetic dental care.

(~~4~~10) General anesthesia or intravenous/conscious sedation unless specifically listed as a benefit or is given by a dentist for covered oral surgery.

~~(5) Experimental procedures.~~

~~(6) Dental conditions arising out of and due to a subscribers employment for which Worker's Compensation or an Employer's~~

~~Liability Law is payable. The participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating dental plan is reimbursed for such benefits.~~

~~(7) Services which were provided without cost to the subscriber by State government or an agency thereof, or any municipality, county or other subdivisions.~~

(~~8~~11) Hospital charges of any kind.

(~~9~~12) Major surgery for fractures and dislocations.

(~~10~~13) Loss or theft of dentures or bridgework.

~~(11) Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the subscriber became eligible for such services.~~

~~(12) Any service that is not specifically listed as a covered benefit.~~

(~~13~~14) Malignancies.

(~~14~~15) Dispensing of drugs not normally supplied in a dental office.

(~~15~~16) Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the subscriber.

(~~16~~17) The cost of precious metals used in any form of dental benefits.

(~~17~~18) The surgical removal of implants.

(~~18~~19) Services of a pedodontist/pediatric dentist for subscriber children except when a subscriber child is unable to be treated by his or her panel provider or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her panel provider is a pedodontist/pediatric dentist.

~~(19) Services which are eligible for reimbursement by insurance or covered under any other insurance, health care service plan, or dental plan. The participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate~~

~~to assure that the participating dental plan is reimbursed for such benefits.~~

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.63 and 12693.755, Insurance Code.

Section 2699.6715 is amended to read:

2699.6715. Share of Cost for Dental Benefits for Subscriber Children.

(a) Every participating dental health plan shall require copayments for the dental benefits listed in Subsection 2699.6709 (a) of these regulations provided to subscribers subject to the following:

(1) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(1), “Diagnostic and Preventive Benefits.”

(2) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(2), “Restorative Dentistry.”

(3) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(3), “Oral Surgery”, with the following exceptions:

(A) Removal of impacted teeth is subject to a copayment per tooth as follows:

1. Soft tissue impaction -- No copayment.

2. Bony impaction -- $5 copayment per tooth.

(B) Root recovery -- $5 per root.

(4) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(4), “Endodontics”, with the following exceptions:

(A) Root canal --therapy $5 per canal. <u>$5.00 copayment per canal for retreatment of previous root canal.</u>

(B) An apicoectomy performed in conjunction with root canal therapy is subject to a copayment of $5 per canal. When

performed as a separate procedure, an apicoectomy is subject to a copayment of $5 per canal.

(5) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(5), “Periodontics”, with the following exceptions:

(A) Osseous or muco-gingival surgery -- $5 per quadrant.

(B) Gingivectomy -- no copayment.

(6) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(6), “Crowns and Fixed Bridges” with the following exceptions:

(A) Porcelain crowns; porcelain fused to metal crowns; full metal crowns; and gold onlays or 3/4 crowns; are each subject to a copayment of $5.

(B) Pontics are each subject to a copayment of $5.

(7) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(7), “Removable Prosthetics”, with the following exceptions:

(A) Dentures are subject to copayments as follows:

1. Complete maxillary denture --$5.

2. Complete mandibular denture -- $5.

3. Partial acrylic upper or lower denture with clasps--$5.

4. Partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles -$5.

5. Removable unilateral partial denture -- $5.

(B) Reline for an upper, lower or partial denture is subject to a copayment per unit as follows:

1. Office reline -- No copayment.

2. Laboratory reline --$5.

(C) Denture duplication-- $5.

(8) No copayments shall be charged for benefits listed under Subsection 2699.6709(c)(8), “Orthodontia.”

(9) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(9), “Other”.

(10) The copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.

(11) Notwithstanding any other provision in this section, an alternative copayment shall apply under the following circumstances: For children under six years of age, who are unable to be treated by their panel provider, and who have been referred to a pedodontist/pediatric dentist, the copayment is $5.

(b) A fee of $5 shall be charged for failure to cancel an appointment without 24 hours prior notification.

(c) No deductibles shall be charged to subscriber children for dental benefits.

(d) No copayments or fees shall apply if the applicant has submitted acceptable documentation as described in Subsection 2699.6600(c)(1)(GG) that the applicant or subscriber is American Indian or Alaska Native.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.63, Insurance Code.

Section 2699.6717 is amended to read:

2699.6717. Share of Cost for Dental Benefits for Subscriber Parents.

(a) Every participating dental plan shall require copayments for the dental benefits provided to subscriber parents subject to the following:

(1) No copayments shall be charged for benefits listed under Subsection 2699.6711(a)(1), “Diagnostic and Preventive.”

(2) No copayments shall be charged for benefits listed under Subsection 2699.6711(a)(2), “Restorative Dentistry”, with the following exceptions:

(A) Micro filled resin restorations (non-cosmetic, acid etched, bonded, light cured):

1. $40 per surface

2. $65 for two or more surfaces

(3) No copayments shall be charged for benefits listed under subsection 2699.6711(a)(3), “Oral Surgery”, with the following exceptions:

(A) Removal of impacted teeth is subject to a copayment per tooth as follows:

1. Partially bony impaction -- $15 copayment.

2. Complete bony impaction -- $15 copayment.

(B) Root recovery as a separate procedure -- $5 per root.

(4) No copayments shall be charged for benefits listed under Subsection 2699.6711(a)(4), “Endodontics” with the following exceptions:

(A) Root canal therapy <u>or retreatment of previous root canal therapy</u> (excluding restoration) is subject to copayments as follows:

1. 1 canal - $20

2. 2 canals - $40

3. 3 canals - $60

4. 4 canals - $80

(B) An apicoectomy performed in conjunction with filling or root canal therapy at the same time is subject to a copayment of

$60 per canal. When performed as a separate procedure, an apicoectomy is subject to a copayment of $50 per canal.

(5) No copayments shall be charged for benefits listed under subsection 2699.6711(a)(5), “Periodontics”, with the following exceptions:

(A) Osseous or muco-gingival surgery is subject to a copayment of $150 per quadrant (includes post surgical visits).

(B) Gingivectomy is subject to a $5 copayment per tooth (fewer than six teeth).

(6) No copayments shall be charged for benefits listed under subsection 2699.6711(a)(6), “Crowns and Bridges” (per unit), with the following exceptions:

(A) Porcelain crowns; porcelain fused to metal crowns (excluding molars) full crowns, or 3/4 crowns; are each subject to a copayment of $50. Cast post and core are subject to $40 per unit copayment, and bonded Maryland Bridge is subject to $50 copayment per unit.

(B) Pontics are each subject to a copayment of $50.

(7) “Removable Prosthetics” as listed under Subsection 2699.6711(a)(7) are subject to the following copayments:

(A) Dentures are subject to copayments as follows:

1. Complete upper denture (3 adjustments within 60 days) - $65.

2. Complete lower denture (3 adjustments within 60 days) - $65.

3. Partial acrylic upper or lower denture with clasps - $5.

4. Partial acrylic upper or lower denture with 2 chrome cobalt allow clasps is subject to a base fee of $65.

5. Partial lower or upper denture with chrome cobalt allow, lingual or palatal bar, clasps and acrylic saddles - $65 base fee (included two clasps).

6. Removable unilateral partial denture - $50.

7. Stayplate (maximum two teeth included) - $60.

(B) Reline for an upper, lower or partial denture is subject to a copayment per unit as follows:

1. Office reline – No copayment.

2. Laboratory reline - $15 copayment.

(C) Denture duplication -- $20 copayment.

(D) Denture Repairs

1. Adding teeth to partial denture to replace natural tooth:

First tooth - $10 copayment.

Each additional tooth - $5 copayment.

2. Broken partial denture (no teeth involved)

Replacement broken clasp - $5 copayment.

3. Add clasp with rest - $5 copayment.

(8) Other Services

After hour visit - $35 copayment.

Broken appointment - $5 copayment.

(9) Implants – If implants are utilized, the plan will apply the cost of a standard full or partial denture towards the cost of implants and appliances constructed thereon, and if performed, subscriber parent must pay the difference plus any applicable copayment. Surgical removal of implants is not covered.

(b) No deductibles shall be charged to subscriber parents for dental benefits.

(c) No copayments or fees shall apply if the applicant has submitted acceptable documentation as described in Subsection 2699.6600(c)(1)(GG)that the applicant or subscriber is American Indian or Alaska Native.

(d) Note: Any procedure not listed in the EOC is available on a fee-for service basis.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.63 and 12693.755, Insurance Code.

Section 2699.6721 is amended to read:

2699.6721. Scope of Vision Benefits.

(a) The basic scope of benefits offered by a participating vision plan ~~as a vision benefit plan~~ must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to the exclusions listed in Section 2699.6723. No other vision benefits shall be permitted to be offered by a participating vision plan as part of the program. The basic scope of vision benefits shall be as follows:

(1) Examinations: Each subscriber shall be entitled to a comprehensive vision examination, including a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities as follows:

(A) Case history: Review of subscriber's main reason for the visit, past history, medications, general health, ocular symptoms, and family history.

(B) Evaluation of the health status of the visual system; including:

1. External and internal examination, including direct and/or indirect ophthalmoscopy;

2. Assessment of neurological integrity, including that of pupillary reflexes and extraocular muscles;

3. Biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctiva, lids and lashes;

4. Screening of gross visual fields; and

5. Pressure testing through tonometry.

(C) Evaluation of refractive status, including:

1. Evaluation for visual acuity;

2. Evaluation of subjective, refractive, and accommodative function; and

3. Objective testing of a patient's prescription through retinoscopy.

(D) Binocular function test.

(E) Diagnosis and treatment plan, if needed.

(F) Examinations are limited to once each twelve month benefit ~~twelve month~~ period, beginning July first of each year ~~which begins with the date of the last exam~~.

(2) When the vision examination indicates that corrective lenses are necessary, each subscriber is entitled to necessary frames and lenses, including coverage for single vision, bifocal, trifocal, ~~and~~ lenticular, tinted, photochromic, and polycarbonate lenses as appropriate.

Frames and lenses are limited to once each twelve month benefit ~~twelve month~~ period, beginning July first of each year ~~which begins with the date of the last exam~~.

(3) Contact lenses shall be covered as follows:

(A) Necessary contact lenses shall be covered in full upon prior authorization from the vision plan, for certain conditions. These conditions may include the following:

1. Following cataract surgery;

2. To correct extreme visual acuity problems that cannot be corrected with spectacle lenses;

3. Certain conditions of Anisometropia; and

4. Keratoconus.

(B) Elective contact lenses may be chosen instead of corrective lenses and a frame at a maximum benefit allowance of $110, which includes examinations, fittings and lenses.

(C) Contact lenses are limited to once each twelve month benefit ~~twelve month~~ period, beginning July first of each year ~~which begins with the date of the last exam~~.

(4) A low vision benefit shall be provided to subscribers who have severe visual problems that are not correctable with regular lenses. This benefit requires prior approval from the participating vision plan. With this prior approval, supplementary testing and supplemental care, including low vision therapy as visually necessary or appropriate, shall be provided.

For subscriber parents, the covered person is required to pay a $5 copayment for any approved Low Vision services.

(5) Participating vision plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating vision plans shall provide services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.

(b) (1) The scope of vision benefits shall also include all vision benefits which are covered under the California Children's Services Program (Health and Safety Code Section 123800 et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber under the age of 21 is determined by the California Children's Services Program to be eligible for vision benefits under that program, a participating vision plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating vision plan shall be available to the subscriber.

(c) If, pursuant to any Workers' Compensation, Employer's Liability Law, or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of vision services to treat any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain, the participating vision plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating vision plan is reimbursed for such services.

(d) Coverage provided under the Healthy Families Program is secondary to all other coverage, except Medi-Cal. Benefits paid under this Program are determined after benefits have been paid as a result of a subscriber's enrollment in any other vision care program. If vision services are eligible for reimbursement by insurance or covered under any other insurance or vision care service plan, the participating vision plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating vision plan is reimbursed for such services.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.65, 12693.66 and 12693.755,-Insurance Code.

Section 2699.6723 is amended to read:

2699.6723. Excluded Vision Benefits.

(a) A vision benefits plan offered under this program shall exclude:

(1) Any benefits specified as excluded within Section 2699.6721 or Section 2699.6722.

(2) Any benefits in excess of limits specified in Section 2699.6721 or Section 2699.6722.

(3) Services, supplies, items, procedures or equipment, which are not medically necessary as determined by the plan, unless otherwise specified in Section 2699.6721 or Section 2699.6722.

(4) Any benefits that were received prior to the subscriber's effective date of coverage.

(5) Any benefits that were received subsequent to the time the subscriber's coverage ends.

~~(1) Benefits which are neither necessary nor appropriate.~~

(~~2~~ 6) Benefits that ~~which~~ are not obtained in compliance with the rules and policies of the subscriber's vision plan.

(~~3~~ 7) Orthopics or ~~V~~vision training and any associated supplemental testing.

(~~4~~ 8) Aniseikonic lenses.

(~~5~~ 9) Plano lenses.

(~~6~~ 10) Two pairs of glasses in lieu of bifocals, unless medically necessary and with the prior authorization of the vision plan.

(~~7~~ 11) Replacement or repair of lost or broken lenses or frames ~~and lenses or frames lost or broken prior to being eligible for services~~.

(~~8~~ 12) Medical or surgical treatment of the eyes.

~~(9) Services or materials for which the subscriber is covered under a Worker's Compensation policy. The participating vision plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating vision plan is reimbursed for such benefits.~~

(~~10~~ 13)Eye examinations required as a condition of employment.

~~(11) Services or materials provided by any other group benefit providing for vision care.~~

(14) Any additional costs over and above the plan's frame allowance, as specified in subsections 2699.6725(a)(2) and 2699.6725(b)(2).

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.65 and 12693.755, Insurance Code.

Section 2699.6725 is amended to read:

2699.6725. Share of Cost for Vision Benefits.

(a) A participating vision plan shall require copayments for benefits provided to subscribers utilizing the services of the vision plan's panel of approved providers subject to the following:

(1) Examinations: $5 copayment per examination.

(2) Frames and lenses: $5 copayment, for frames with lenses, or for frames or lenses when purchased separately. No additional copayment for tinted, photochromic, or polycarbonate lenses.

~~A wholesale frame allowance of $30 will be provided by the vision plan. If a subscriber chooses a frame with a wholesale value above $30, the provider will bill the subscriber the difference between the standard retail value of $75 for a $30 wholesale frame and the retail cost of the frame the subscriber has selected~~. A frame allowance of $75 is provided by the vision plan. The subscriber is responsible for any costs exceeding this allowance for the following options:

~~The following options are considered cosmetic and any costs associated with the selection of these options will be the financial responsibility of the applicant.~~

(A) Blended lenses (bifocals which do not have a visible dividing line).

(B) Contact lenses except as specified in Section 2699.6721(a)(3).

(C) Oversized lenses (larger than standard lens blank to accommodate prescriptions).

(D) Progressive multifocal lenses.

(E) Coated or laminated lenses.

(F) UV protected lenses.

(G) Other optional cosmetic processes.

(H) A frame that costs more than the plan's allowance.

(3) Necessary contact lenses, as defined in Subsection 2699.6721(a)(3): No copayment.

(4) Elective contact lenses: an allowance of $110 will be provided by the vision plan toward the cost of an examination, contact lens evaluation, fitting costs and materials. This allowance will be in lieu of all benefits including examination and material costs. The subscriber is responsible for any costs exceeding this allowance.

(5) Low vision benefits:

(A) Supplementary testing: No copayment; and

(B) Supplemental care: $5 copayment.

(b) Services from providers not included in the vision plan's panel of approved providers:

When a subscriber obtains services from a provider not included in the vision plan's panel of approved providers, the applicant will be responsible for paying the provider for all services and materials received at the time of their appointment. The participating vision plan will reimburse the applicant within fourteen (14) calendar days after receipt of the paid itemized bill or statement, according to the schedule of allowances as follows:

(1) Professional fees:

(A) Vision exams - up to $35.00

(2) Materials:

(A) Each single vision lens - up to $12.50 or a pair of single vision lenses up to $25.00.

(B) Each bifocal lens - up to $20.00 or a pair of bifocal lenses up to $40.00

(C) Each trifocal lens - up to $25.00 or a pair of trifocal lenses up to $50.00.

(D) Each lenticular lens - up to $50.00 or a pair of lenticular lenses up to $100.00.

(E) Frame~~,~~ up to $40.00

(F) Tinted or photochromic lenses ~~allowance~~ - up to $5.00

(G) Polycarbonate lenses - up to $10.00

(~~G~~ H) Each pair of necessary contact lenses - up to $250.00

(~~H~~ I) Each pair of elective contact lenses, up to $110.00. Determination of whether contact lenses are necessary or elective when obtained from providers not included in the vision plan's panel of approved providers will be the responsibility of the vision plan. Reimbursement for elective contact lenses is in lieu of all benefits, including examination and materials.

(3) Low vision benefits: Low vision benefits obtained from a provider not included in the vision plan's panel of approved providers will be reimbursed in accordance with what the participating vision plan would pay a provider included in the vision plan's panel of approved providers for this benefit.

(c) No deductibles shall be charged to subscribers for vision benefits.

(d) For subscriber parents who receive vision services from one of the participating member doctors, covered services as described are provided with no additional out-of-pocket costs after an applicable copayment. Additional services selected for cosmetic purposes are the financial responsibility of the patient.

(e) No copayments shall apply if the applicant has submitted acceptable documentation as described in Section 2699.6600(c)(1)(GG) that the applicant or the subscriber is American Indian or Alaska Native. However, there is no limitation on the payments required under Subsection (b) above.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.65 and 12693.755, Insurance Code.

Summary And Response To Public Comments
Regarding The Implementation of AB 343 (2004) Healthy Families Program
Provisions on Plan Transfers and Clarification of Benefits

Public Comments were received from three (3) organizations:

1. **Strathmore Union Elementary School District Healthy Start Preschool Program**
2. **Blue Cross of California**
3. **Molina Healthcare**

Strathmore Union Elementary School District Healthy Start Preschool Program
Public Comment 1

Comment 1a: Section 2699.6619(a)(5)(b)

Strathmore Union Elementary School District, Healthy Start Preschool Program (SUESD) supports the provisions of AB 343 that would allow Healthy Families Program (HFP) subscribers to change plans for any reason within first three months of coverage.

Response:

Because the proposed regulations would allow HFP subscribers to change plans for any reason within the three months of coverage, the Managed Risk Medical Insurance Board (MRMIB) will make no change to the proposed regulations.

Comment 1b: (No section cited.)

SUESD states the changes proposed by AB 343 should not impact the financial responsibility of HFP families.

Response:

The proposed regulation changes do not affect the cost of premium payments made by HFP families. Therefore, no changes will be made to the proposed regulations.

Comment 1c: Section 2699.6619(a)(5)(b)

SUESD states that dental and vision plans should be given the same consideration as medical coverage for HFP subscribers, and that such a change will assure conformity in the regulation of the HFP enrollment process.

Response:

These proposed regulation changes do provide conformity to HFP dental, and vision plans as well as health plans to allow subscribers to change plans for any reason within the first three months of coverage. For that reason, no changes to the proposed regulations will be made.

Blue Cross of California
Public Comment 2

Comment 2a: Section 2699.6700(a)(10)(A) previously Section 2699.6700(a)(12)(A)

Blue Cross (BC) states currently under Section 2699.6619 plans are required to cover unlimited "visits" for persons with severe mental illness (SMI). BC states that the proposed regulations will require plans to cover unlimited "in-patient days" for persons with SMI. BC also defines "visit" as an outpatient professional therapy visit, while "in-patient day" is defined as an intensive facility based treatment. BC states the change in language would change the way their organization provides the mental health benefit and have direct cost implications.

Response:

The change of terminology from "visit" to "inpatient day" occurs in the section of the regulation dealing with coverage for inpatient mental health benefits "during a *certified confinement in a participating hospital* when ordered and performed by a participating mental health provider for the treatment of a mental health condition." (Section 2699.6700 (a)(10)(A); emphasis added.) The word "visit" is not accurate in this context because the benefit relates to confinement in a hospital. Therefore, the benefit should be described as an "inpatient day." Replacing "visit" with "inpatient day" clarifies that plans are required to provide inpatient mental health services with no limits for severe mental illnesses as described in the regulation. This language does not change the inpatient mental health benefit. Therefore, MRMIB rejects the comment.

Comment 2b: (No section cited)

BC would like MRMIB to consider a provision requiring families to cooperate with the referral process and the Serious Emotional Disturbance (SED) evaluation conducted by the counties. BC states the reason this is needed is because some families would

rather have their children's mental health benefits provided through the plan, and are therefore refusing to have their child take the SED evaluation. Subsequently, instead of providing up to 30 days of service for children with a SED condition, the plan is providing unlimited services which increase costs. The commenter further suggests the intent of the referral process is being negated.

Response:

The recommendation is not directed at the agency's proposed action or the procedures followed by the agency in proposing or adopting the action. Therefore, MRMIB rejects the comment.

Molina Healthcare
Public Comment 3

Comment 3a: Section 2699.6700(a)(1)(A)

Molina Healthcare (MH) suggests the proposed regulation change to delete the words "medically necessary" in Section 2699.6700 will cause confusion.

Response:

Section 2699.6703(a)(3) provides that services, supplies, items, procedures or equipment which are not medically necessary are excluded from health benefits plans unless otherwise stated in Section 2699.6700. In addition, the health plan determines medical necessity. Continuing to repeat the standard of medically necessary services and equipment would be redundant. Therefore, this comment is rejected.

Comment 3b:

MH states modifying the term "visits" to inpatient days" in 2699.6700 (10)(a)(A) changes the plan benefit and potentially increases financial risk to the health plan.

Response:

For the reasons stated in response to Blue Cross Comment 2a, the comment is rejected.

Comment 3c:

MH states modifying the term "determination" to "evaluation" in Section 2699.6700 (a)(10)(A) is unclear. And states that it is unclear how this change impacts the process whereby the county mental health department evaluates the patient for Serious Emotional Disturbances (SED).

Response:

MRMIB believes that the term "evaluation" better described the SED process. Typically, the term "evaluation" means "a diagnosis or diagnostic study of a physical or mental condition." By contrast, the term "determination" means "the act of coming to a decision or a fixing or settling a purpose." (Dictionary.com.) For that reason, MRMIB rejects the comment.

Comment 3d:

MH asked for clarification as to whether the change in Section 2699.600 (a)(10)(B) which deletes language permitting health plans to limit outpatient mental health coverage to 20 days per benefit year and replaces it with language that requires health plans to provide up to at least 20 outpatient mental health visits per year constitutes a material change to the outpatient mental health benefit.

Response:

MRMIB believes MH is referring to Section 2699.6700(a)(10)(B). MRMIB is not replacing language that requires health plans to provide at least 20 outpatient mental health visits per year. It is making a technical change because the current regulations state both that the plans "must provide up to at least 20 visits per benefit year" and that "Plans may limit coverage to 20 days per benefit year..." for some conditions. The statement that plans may limit coverage to 20 days per benefit year is being deleted to remove the contradiction in language and provide clarity in the existing regulation subsection. This change continues to allow plans to provide more than 20 outpatient mental health visits per benefit year if needed. Therefore, this comment is rejected.

R-1-06 Comment 1
HFP Benefits Update

Strathmore Union Elementary School District
Healthy Start Preschool Program
22898 Ave. 198 P.O. Box 247
Strathmore, CA 93267
(559) 568-0007 FAX (559) 568-0467

August 9, 2007

MRMIB
Attn: JoAnne French
1000 G Street, Suite 450
Sacramento, CA 95814

Dear Ms. French,

I support AB 343 to include a provision that would allow HFP subscribers to change plans for any reason within the first three months of coverage. Dental and vision plans should be given the same consideration as medical coverage for HFP subscribers. Such change will assure conformity in the regulation of HFP enrollment process.

MRMIB has done an excellent job in administering the HFP. Continued support and advocacy for the HFP will confirm MRMIB's committment to families and children.

Additionally, if it is determined that changes take place as proposed in AB 343, such changes should not impact the financial responsibility of HFP families. HFP provides exceptional medical, dental, and vision coverage to families. Families and children will benefit immensely if monthly premiums are not increased.

Respectfully,

Isidro Silva, Jr.
Entity Number: 83184
CAA Number: 0000960A
Preschool Manager
Healthy Start Preschool

September 26, 2007

The Honorable Lesley Cummings
Executive Director, California Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento CA 95814

RE: REVISED HEALTHY FAMILIES PROGRAM REGULATIONS

Dear Executive Director Cummings:

On behalf of Blue Cross of California (BCC), we have the following comments regarding the proposed changes to the Healthy Families Program.

Currently in Section 2699.6619, plans are required to cover unlimited "visits" for persons with severe mental illness (SMI). These proposed regulations would require plans to cover unlimited "inpatient days" for persons with SMI. We define "visit" as an outpatient professional therapy visit, while "inpatient day" is defined as an intensive facility-based treatment such as inpatient (acute), residential treatment (24-hour care), or day treatment, where the member attends a treatment program for at least 5 hours per day, but does not sleep there.

MRMIB states that this change is for clarity; however, Blue Cross of California defines these two terms in vastly different ways. This change will alter the way Blue Cross provides the mental health benefit, which has direct cost implications.

Additionally, we would like you to consider a provision requiring that the parents and/or families cooperate with the referral process and the Serious Emotional Disturbance (SED) evaluation conducted by the counties. Currently, children determined as having an SED condition per the evaluation are transferred to their county for services. Plans have to provide up to 30 days of services, per benefit year for children with an SED condition. We have noticed that many families would rather have their benefits provided via their health plan. Because of this, we have experienced many families who refuse to have their child take the SED evaluation. If they are not determined as having an SED, then under this proposed regulation, we would have to provide unlimited services, which would also increase costs and negate the original intent of the referral process.

We appreciate your consideration of these comments. Should you have any questions, please do not hesitate to contact us at (916) 447-9280.

Sincerely,

Angelica V. González
Director of Government Relations
Blue Cross of California

MOLINA HEALTHCARE

R-1-06 Comment 3
HFP Benefits Update

September 26, 2007

Via Email: *jfrench@mrmib.ca.gov*

Managed Risk Medical Insurance Board
Attn: JoAnne French
1000 G Street, Suite 450
Sacramento, CA 95814

RE: Healthy Families Program Plan Benefits and Selection Conforming Proposed Regulations; R-1-06

Dear Ms. French:

On behalf of Molina Healthcare of California, I am providing the Managed Risk Medical Insurance Board (MRMIB) with our comments regarding the proposed regulation changes to plan benefits, as referenced above. Molina Healthcare has participated in public programs for more than 25 years; with the specific mission of caring for those patients traditionally facing barriers to health care. We, therefore, speak from experience. Further, we add significant value to local communities by operating 19 primary care clinics in predominately economically disadvantaged and underserved areas. Our clinics treat not only Molina Healthcare members, but the uninsured as well. Molina Healthcare participates in the Medi-Cal Program, Healthy Families and Access for Infants and Mothers Programs.

The following includes specific comments, addressing particular sections. We appreciate the efforts undertaken by MRMIB to streamline the benefit regulations, delete redundancies, as well as to restructure and clarify benefit names for consistency with state and federal law.

The specific areas of concern are:

- The deletion of the words "medically necessary" in several sections of the proposed regulations (i.e. Title 10 CCR Section 2699.6700(a)(1)(A) Inpatient Hospital Services). MRMIB states this language is not necessary because Section 2699.6703(a)(3) specifically excludes "Services, supplies, items, procedures or equipment, which are not medically necessary as determined by the plan, unless otherwise specified in Section 2699.6700". Other sections where MRMIB proposes to delete "medically necessary" are: (a)(2) Professional Services, (a)(3)(G) Maternity Services, (a)(6) Orthotics and

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Prosthetics, (a)(15) Skilled Nursing Care, (a)(16) Physical, Occupational, and Speech Therapy, and (a)(22) Transplants. The deletion of the words "medically necessary" will have the unintended consequence of causing confusion, and MRMIB should rethink these portions of the proposed regulations.

- Mental Health: Title 10 CCR Section 2699.6700(a)(10)(A) of the proposed regulations modifies the term "visits" to "inpatient days". This modification appears to change the plan benefit, and potentially increase the financial risk to the health plan. MRMIB should clarify if this proposed revision constitutes a material change to the benefit.

- Mental Health: Title 10 CCR Section 2699.6700(a)(10)(A) of the proposed regulations modifies the term "determination" to "evaluation". It is unclear how this modification impacts the process whereby the county mental health department "evaluates" the individual for Serious Emotional Disturbances (SED). MRMIB should clarify if this proposed revision constitutes a material change to the benefit.

- Mental Health: Title 10 CCR Section 2699.600(a)(10)(B) of the proposed regulation deletes language permitting health plans to limit coverage to 20 days per benefit year. However, the proposed regulation requires health plans to provide up to at least 20 visits per benefit year. This section governs treatment for illnesses that meet neither the criteria for severe mental illnesses, nor the criteria for SED of a child or a serious mental disorder. MRMIB should clarify if this proposed revision constitutes a material change to the benefit.

Molina Healthcare appreciates the opportunity to provide comments on the proposed regulation. Should you have any questions, please feel free to contact me at (562) 499-6191 ext. 127063.

Sincerely,

Andrew K. Whitelock
Director, Government Contracts

cc: Kelly Ryan, Associate General Counsel
John M. Puente, Deputy Assistant General Counsel

AKW/drc

MANAGED RISK MEDICAL INSURANCE BOARD
RESOLUTION

After considering the public comments submitted to the Board, the Board hereby approves the final adoption of regulations to implement AB 343 (Statutes of 2004) provisions on plan transfers and to clarify Healthy Families Program, Regulation Packet R-1-06.

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CERTIFICATION

I, Lesley Cummings, Executive Director of the Managed Risk Medical Insurance Board, do hereby certify that the foregoing action was duly passed and adopted by the Managed Risk Medical Insurance Board at an official meeting thereof on June 23, 2008.

Dated this 23rd day of June, 2008.

_____

Lesley Cummings, Executive Director
Managed Risk Medical Insurance Board